5101:3-2-24 ~~-~~ Audits.

(A) General provisions.

(1) Audits will be conducted by the department for services rendered by the hospital under the medicaid~~, general assistance~~ and disability assistance programs. The examination of hospital costs and charges will be made in accordance with generally accepted auditing standards necessary to fulfill the scope of the audit. To facilitate this examination, providers are required to make available all records necessary to fully disclose the extent of services provided to program recipients, the corresponding costs and charges made and payments received for such services, and the provider's audited financial statement for the period corresponding to the cost-reporting period. The principle objective of the audit is to enable the department to determine that payment has been, or will be made, in accordance with federal/state and department requirements. Based on the audit, adjustments in payments to the provider will be made as required by provisions of this rule. Records necessary to fully disclose the extent of services provided must be maintained for a period of six years or, if an audit has been initiated, until the audit is completed and every exception is resolved. Said records must be made available, upon request, to the Ohio department of human services (ODHS) for audit purposes. No payment for outstanding medical services can be made if a request for audit is refused.

(2) Additionally, audits will be performed to verify hospital costs and charges utilized in the determination of the hospital's contribution to and reimbursement from the hospital care assurance fund and disproportionate share fund as described in RULES ~~rule~~ 5101:3-2-08, 5101:3-2-09 AND 5101:3-2-10 ~~5101:3-2-0715~~ of the Administrative Code. ~~Providers requesting to qualify under the provisions of paragraphs (D)(2) and (D)(3) of rule 5101:3-2-0715 of the Administrative Code are required to make available all records necessary to fully disclose the extent of services and corresponding cost and charges to patients who at the time of service did not reside in the county in which the hospital is located. The information with respect to services to out-of-county patients must be compiled in county and zip code order and must contain the patient's full name, complete address, telephone number, county, dates of service and charges.~~

(3) All audit activities described in this rule may be undertaken during any rate year for the purpose of assuring accuracy of data maintained by the department.

(B) Scope of audits for hospital services reimbursed on a reasonable cost basis.

(1) For hospital services reimbursed on a reasonable cost basis as identified in rule 5101:3-2-22 of the Administrative Code, audits are performed to determine whether:

(a) Services billed were provided;

(b) Services were provided to persons eligible as medicaid recipients on the date(s) services were rendered;

(c) Services billed are covered under the medicaid program in accordance with Chapter 5101:3-2 of the Administrative Code;

(d) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with the provisions of rule 5101:3-2-22 of the Administrative Code;

(e) Payments made to the hospital for services rendered during the cost period being audited were sufficient or insufficient in relation to audit findings;

(f) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 CFR 447.253;

(g) Amounts of third-party payments reported to the department as described in rules 5101:3-1-08 and 5101:3-2-25 of the Administrative Code reflect the actual amounts received;

(h) For the purpose of updating interim payment rates that are subject to cost settlement, desk audit procedures will take into consideration the relationship between prior year's reported costs and audited costs; and

(i) Amounts paid by the hospital and payments made by ODHS related to the indigent care adjustments described in ~~rule~~ RULES 5101:3-2-09 AND 5101:3-2-10 ~~5101:3-2-0715~~ of the Administrative Code were based upon data described in RULES ~~rule~~ 5101:3-2-09 AND 5101:3-2-10 ~~5101:3-2-0715~~ of the Administrative Code.

(2) Underpayments or overpayments determined as a result of findings made under the provisions of paragraphs (B)(1) to (B)(1)(h)~~(i)~~ of this rule will be reconciled at the time of final settlement as described in paragraph (D)~~(E)~~(2) of this rule taking into account any adjustments made during interim settlements as provided in rule 5101:3-2-23 of the Administrative Code.

(3) Audits performed in relation to the disability assistance ~~and general assistance~~ medical ~~programs~~ PROGRAM are performed for the purposes described in paragraphs (B)(1)(a) to (B)(2) of this rule, except that the provisions of Chapter 5101:3-23 of the Administrative Code govern findings relative to service coverage and recipient eligibility.

~~(C) Termination of reasonable cost reimbursement for certain inpatient and outpatient hospital services furnished by hospitals subject to prospective payment.~~

~~(1) As identified in rule 5101:3-2-071 of the Administrative Code, certain hospitals are subject to prospective payment for inpatient services associated with admissions provided on and after October 1, 1984. For those hospitals having fiscal years beginning prior to October 1, 1984, audits and settlements for inpatient services provided before October 1, 1984 are performed under the provision described in this paragraph. The hospital's reporting period beginning with the hospital's fiscal year and ending the day prior to October 1, 1984 will be cost-settled on a prorated basis. Under this provision, the hospital submits a full fiscal year cost report in accordance with rule 5101:3-2-23 of the Administrative Code. Allowable costs for the portion of the reporting period prior to October 1, 1984 are determined as follows:~~

~~(a) The department determines total allowable costs for the hospital's fiscal year in accordance with paragraphs (A) to (B)(3) of this rule.~~

~~(b) Based on the best available information submitted by the hospital and approved by the department, the department determines the per cent of total covered medicaid days for the reporting period which represent covered medicaid days applicable to dates of service prior to October 1, 1984.~~

~~(c) Allowable costs (as determined under paragraph (C)(1)(a) of this rule) are multiplied by the per cent of covered medicaid days determined under paragraph (C)(1)(b) of this rule. The resulting amount represents allowable medicaid costs for the portion of the hospital's fiscal year preceding October 1, 1984.~~

~~(2) As identified in rule 5101:3-2-21 of the Administrative Code, certain outpatient services are no longer subject to reasonable cost reimbursement for services provided on and after July 1, 1988. Allowable costs for the portion of the hospital's reporting period prior to July 1, 1988 are determined in accordance with paragraph (B) of this rule and the provisions of rule 5101:3-2-20 of the Administrative Code.~~

(C)~~(D)~~ Scope of audits for hospital services reimbursed on a prospective payment basis ~~other than reasonable cost reimbursement.~~

(1) For hospitals services subject to prospective payment, audit activities are undertaken for several purposes. For each cost-reporting period, cost reports are audited, following the criteria outlined in paragraphs (C)~~(D)~~(1)(a) to (C)~~(D)~~(1)(e) of this rule for the purpose of reaching interim and final settlement with a hospital. For determination of amounts related to indigent care adjustment provisions described in RULES ~~rule~~ 5101:3-2-09 AND 5101:3-2-10 ~~5101:3-2-0715~~ of the Administrative Code, audit steps will be performed following the criteria outlined in paragraph (C)~~(D)~~(1)(h) of this rule. During years in which prospective payments are being rebased, additional activities such as those described in paragraphs (C)~~(D)~~(1)(f) and (C)~~(D)~~(1)(g) of this rule are undertaken to establish program costs used for the calculations described in rule 5101:3-2-074 of the Administrative Code. For hospital services identified in rule 5101:3-2-071 of the Administrative Code as being subject to prospective payment, desk or field audits of interim cost reports are performed to determine whether:

(a) Services billed were provided;

(b) Services billed were provided to persons eligible as medicaid recipients on the date(s) services were rendered;

(c) Services billed are covered under the medicaid program in accordance with Chapter 5101:3-2 of the Administrative Code;

(d) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 CFR 447.253;

(e) Amounts of third-party payments reported to the department as described in rules 5101:3-1-08 and 5101:3-2-25 of the Administrative Code reflect the actual amounts received;

(f) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with rule 5101:3-2-22 of the Administrative Code; and

(g) Medicaid discharges and associated charges and days as reported on the cost report are consistent with those reflected for the same period in the ODHS

paid claims history. In cases where data submitted by the hospital on the cost report are inconsistent with data in the ODHS paid claims data file, the cost report is subject to adjustment as described in paragraph (D)(2) of this rule. Inconsistencies subject to adjustment include, but are not limited to:

(i) Submitted discharges lower than those in the ODHS paid claims data file.

(ii) Submitted charge-to-day ratio lower than that in the ODHS paid claims data file.

(iii) Submitted charges lower than those in the ODHS paid claims data file.

(iv) Other inconsistencies that require analysis and auditor judgment to determine the appropriate type of adjustment.

(h) Amounts related to indigent care adjustments described in RULES ~~rule~~ 5101:3-2-09 AND 5101:3-2-10 ~~5101:3-2-0715~~ of the Administrative Code were based upon data described in ~~rule~~ RULES 5101:3-2-09 AND 5101:3-2-10 ~~5101:3-2-0715~~ of the Administrative Code.

(2) For hospitals subject to prospective payment for inpatient services, the audits may result in the following adjustments:

(a) If the review identified in paragraphs (C)~~(D)~~(1)(g)(i) to (C)~~(D)~~(1)(g)(iv) of this rule indicates that the cost report reflects fewer medicaid discharges and/or a discrepancy exists between reported medicaid charges and those reflected in the ODHS paid claims data file, the interim cost report may be adjusted to reflect inpatient days, charges, and discharge counts from the ODHS paid claims data file.

(b) If the reviews identified in paragraphs (C)~~(D)~~(1)(a) to (C)~~(D)~~(1)(c) and (D)(1)(e) of this rule indicate that inappropriate charges were attributed to medicaid program charges in the cost report, the interim cost report will be adjusted to remove such charges.

(c) If the review described in paragraph (C)~~(D)~~(1)(f) of this rule identifies that nonallowable disallowed costs were included in the cost report, the interim cost report will be adjusted to remove such costs.

(3) ~~Other adjustments provided by the medicare fiscal intermediary, either tentative or final, and supplied to the department as of September 1, 1987, will be incorporated into the interim cost report described in paragraph (D) of rule 5101:3-2-074 of the Administrative Code.~~ Federal audit findings submitted to the department after SEPTEMBER 1, 1987 ~~that time~~ will be implemented as described in rule 5101:3-2-078 of the Administrative Code if the affected rate has been in effect for less than two prospective rate periods following implementation of rebased rate components and if the department notifies the affected hospital of the audit finding within thirty days of receipt of the finding. Hospitals may request reconsideration of the adjustment within thirty days of notification following the procedures outlined in rule 5101:3-2-0712 of the Administrative Code.

(4) Overpayments determined as a result of findings made under the provisions of paragraphs (C)~~(D)~~(1)(a) to (C)~~(D)~~(1)(e) of this rule will be collected by the department.

(D)~~(E)~~ Interim and final settlement

(1) Any adjustments described in paragraphs (C)~~(D)~~(2) and (C)~~(D)~~(3) of this rule will be reflected in the interim or final settlement cost report. Overpayments or underpayments, as described in paragraphs (C)~~(D)~~(1)(a) to (C)~~(D)~~(1)(d) of this rule, will be collected by the department at settlements based upon findings associated with the cost-reporting period being settled. Retrospective adjustments to payment rates as described in rule 5101:3-2-078 of the Administrative Code that are identified prior to interim settlement will be incorporated into interim settlement in instances when such adjustments to payment rates affect payments for discharges occurring during the cost-reporting period being settled.

(2) Final settlement constitutes the implementation of the final fiscal audit for a cost-reporting period.

(a) Any adjustments not incorporated into interim settlement and all applicable retrospective adjustments to payment rates in effect for discharges occurring during the cost-reporting period will be incorporated into final settlement for that cost-reporting period.

(b) Any pending request for reconsideration filed pursuant to paragraphs (B) and (C) of rule 5101:3-2-0712 of the Administrative Code will be incorporated into final settlement.

(c) If a hospital has an outstanding medicare appeal that has not been resolved and that could affect settlement of hospital-specific rate components, the

hospital may accept, with reservations, final settlement incorporating adjustments not based on unresolved medicare audit exceptions and hold open that portion of the settlement, with all rights to appeal under Chapter 119. of the Revised Code, based on unresolved medicare audit exceptions.

(d) In no instance will adjustments to rates that were in effect during the period covered by final settlement be made following final settlement, and only components of rates that are based solely on hospital-specific data are subject to recalculation and adjustment after such rates have been in effect for two prospective payment periods following the implementation of rebased rate components.

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21 APRIL 2000
Date

Promulgated Under RC Chapter 119.

Statutory Authority RC Section 5111.02

Rule Amplifies RC Sections 5111.01 and 5111.02

Prior Effective Dates: 4/7/77, 10/1/84, 7/3/86, 10/19/87, 4/23/88, 8/1/88 (Emer.), 10/13/88, 9/3/91 (Emer.), 11/10/91, 7/1/92

5101:3-2-24 Audits.

(A) General provisions.

(1) Audits will be conducted by the department for services rendered by the hospital under the medicaid, ~~and~~ general assistance AND DISABILITY ASSISTANCE programs. The examination of hospital costs and charges will be made in accordance with generally accepted auditing standards necessary to fulfill the scope of the audit. To facilitate this examination, providers are required to make available all records necessary to fully disclose the extent of services provided to program recipients, the corresponding costs and charges made and payments received for such services, and the provider's audited financial statement for the period corresponding to the cost-reporting period. The principle objective of the audit is to enable the department to determine that payment has been, or will be made, in accordance with federal/state and department requirements. Based on the audit, adjustments in payments to the provider will be made as required by provisions of this rule. Records necessary to fully disclose the extent of services provided must be maintained for a period of six years or, if an audit has been initiated, until the audit is completed and every exception is resolved. Said records must be made available, upon request, to the Ohio department of human services (ODHS) for audit purposes. No payment for outstanding medical services can be made if a request for audit is refused.

(2) Additionally, audits will be performed to verify hospital costs and charges utilized in the determination of the hospital's contribution to and reimbursement from the hospital care assurance fund and disproportionate share fund as described in rule 5101:3-2-0715 of the Administrative Code. Providers requesting to qualify under the provisions of paragraphs (D)(2) and (D)(3) of rule 5101:3-2-0715 of the Administrative Code are required to make available all records necessary to fully disclose the extent of services and corresponding cost and charges to patients who at the time of service did not reside in the county in which the hospital is

located. The information with respect to services to out-of-county patients must be compiled in county and zip code order and must contain the patient's full name, complete address, telephone number, county, dates of service and charges.

(3) All audit activities described in this rule may be undertaken during any rate year for the purpose of assuring accuracy of data maintained by the department.

(B) Scope of audits for hospital services reimbursed on a reasonable cost basis.

(1) For hospital services reimbursed on a reasonable cost basis as identified in rule 5101:3-2-22 of the Administrative Code, audits are performed to determine whether:

(a) Services billed were provided;

(b) Services were provided to persons eligible as medicaid recipients on the date(s) services were rendered;

(c) Services billed are covered under the medicaid program in accordance with Chapter 5101:3-2 of the Administrative Code;

(d) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with the provisions of rule 5101:3-2-22 of the Administrative Code;

(e) Payments made to the hospital for services rendered during the cost period being audited were sufficient or insufficient in relation to audit findings;

(f) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 CFR 447.253;

(g) Amounts of third-party payments reported to the department as described in rules 5101:3-1-08 and 5101:3-2-25 of the Administrative Code reflect the actual amounts received;

(h) For the purpose of updating interim payment rates that are subject to cost settlement, desk audit procedures will take into consideration the relationship between prior year's reported costs and audited costs; and

(i) Amounts paid by the hospital and payments made by ODHS related to the indigent care adjustments described in rule 5101:3-2-0715 of the Administrative Code were based upon data described in rule 5101:3-2-0715 of the Administrative Code.

(2) Underpayments or overpayments determined as a result of findings made under the provisions of paragraphs (B)(1) to (B)(1)(i) of this rule will be reconciled at the time of final settlement as described in paragraph (E)(2) of this rule taking into account any adjustments made during interim settlements as provided in rule 5101:3-2-23 of the Administrative Code.

(3) Audits performed in relation to the DISABILITY ASSISTANCE AND general assistance medical PROGRAMS ~~program~~ are performed for the purposes described in paragraphs (B)(1)(a) to (B)(2) of this rule, except that the provisions of Chapter 5101:3-23 of the Administrative Code govern findings relative to service coverage and recipient eligibility.

(C) Termination of reasonable cost reimbursement for certain inpatient and outpatient hospital services furnished by hospitals subject to prospective payment.

(1) As identified in rule 5101:3-2-071 of the Administrative Code, certain hospitals are subject to prospective payment for inpatient services associated with admissions provided on and after October 1, 1984. For those hospitals having fiscal years beginning prior to October 1, 1984, audits and settlements for inpatient services provided before October 1, 1984 are performed under the provision described in this paragraph. The hospital's reporting period beginning with the hospital's fiscal year and ending the day prior to